EXHIBIT A

Product:	**Direct Access**
Group Name:	**YWCA OF BERGEN COUNTY**
Group Number:	**085916-010** **6617-4**

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INTRODUCTION

This Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) Direct Access Program gives you and your covered Dependents broad protection to help meet the cost of Illnesses and Accidental Injuries. This Program offers the highest level of benefits when services are obtained from a Hospital or other Provider designated as a Direct Access In-Network Provider either in New Jersey or in another Blue Cross and Blue Shield service area.

In this Booklet, you'll find the important features of your group's Direct Access benefits provided by Horizon BCBSNJ. You should keep this Booklet in a safe place and read it carefully so that you become familiar with the benefits that are available to you and your family. This Booklet replaces any booklets and/or certificates you may previously have received.

Coverage under this Program is provided according to the Group Policy for each Covered Person. Your Booklet's Schedule of Covered Services and Supplies shows the Policyholder and the Group Policy Number(s).

Benefits and Amounts:

The available benefits and the amounts of insurance are described in the Booklet.

This Booklet is an important document and should be kept in a safe place. When you become covered under the Program, you will receive a Certificate of Coverage. You should attach the Certificate of Coverage to this Booklet. Together, they form your Group Insurance Certificate.

The Booklet is made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or in a new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Booklet.

Horizon Healthcare Services, Inc. (d/b/a Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ))

3 Penn Plaza East
Newark, New Jersey 07105-2200

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HORIZON HEALTHCARE SERVICES, INC

CERTIFICATE OF COVERAGE

Horizon Healthcare Services, Inc. (Horizon BCBSNJ) certifies that insurance is provided according to the applicable Group Policy for each insured Employee. Your Booklet's Schedule of Covered Services and Supplies shows the Group Policyholder and the Group Policy Number.

Insured Employee: You are insured under the Group Policy. This Certificate of Coverage together with your Booklet forms your Group Insurance Certificate.

Your Booklet and this Certificate of Coverage replace any older booklets and certificates issued to you for the coverage described in your Booklet. The Booklet and Certificate of Coverage are made part of the Group Policy, which is delivered in and governed by the laws of the State of New Jersey. Future changes in coverage will be described in either a Booklet Notice of Change or new Booklet. All benefits are subject in every way to the entire Group Policy, which includes this Group Insurance Certificate.

Horizon Healthcare Services, Inc.
3 Penn Plaza East
Newark, New Jersey 07105-2200

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DEFINITIONS

This section defines certain important terms used in this Booklet. The meaning of each defined word, whenever it appears in this Booklet, is governed by its definition below.

Act of War: Any act peculiar to military, naval or air operations in time of War.

Active: Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Admission: Days of Inpatient services provided to a Covered Person.

Affidavit of Domestic Partner/Statement of Domestic Partnership: A formal instrument executed by two persons documenting their status as Domestic Partners. Submission of an Affidavit of Domestic Partnership/ Statement of Domestic Partnership to the Group and Horizon BCBSNJ is required prior to Domestic Partner coverage becoming effective. In order to be a valid Affidavit of Domestic Partnership/ Statement of Domestic Partnership for purposes of your group's Policy, the definition of Domestic Partners contained therein must be identical to the definition contained in the definition of Domestic Partner.

Affiliated Company: A corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets; or as otherwise defined by the Policyholder and Horizon BCBSNJ.

Alcoholism: The abuse of or addiction to alcohol.

Allowance: An amount determined by Horizon BCBSNJ as the least of the following amounts: (a) the actual charge made by the provider for the service or supply; or (b) in the case of In-Network Providers, the amount that the provider has agreed to accept for the service or supply; or (c) in the case of Out-of-Network Providers, the amount determined for the service or supply based on the Resource Based Relative Value System promulgated by the Centers for Medicare and Medicaid Services; or (d) in the case of Out-of-Network Providers, an amount determined for the service or supply based on: (i) profiles compiled by Horizon BCBSNJ based on the usual and prevailing payments made to providers for similar services or supplies in specific geographical areas; or (ii) similar profiles compiled by outside vendors. In a case where a Covered Person's Primary Care Physician (PCP) refers him/her to an Out-of-Network Provider's services will be the amount determined in accordance with (a), above.

The above methods for determining an Allowance do not apply with respect to the Program coverage of Orthotic and Prosthetic Devices. The Allowance for any such covered device shall be the greater of: (a) the reimbursement rate for the device in the federal Medicare reimbursement schedule; and (b) in the case of In-Network Providers, the amount that the Provider has agreed to accept for the device. If there is no such rate for the device, the amount determined for (a) shall be the Medicare reimbursement rate for the most similar device.

Alternate Payee:

[redacted]

SCHEDULE OF COVERED SERVICES AND SUPPLIES

POLICYHOLDER: YWCA OF BERGEN COUNTY

GROUP POLICY NO.: 085916

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS PROGRAM ARE SUBJECT TO ANY AND ALL DEDUCTIBLE(S), COPAYMENT(S), COINSURANCE(S) AND MAXIMUM(S) STATED IN THIS SCHEDULE AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

NOTE: OUR BENEFITS WILL BE REDUCED FOR NON-COMPLIANCE WITH THE UTILIZATION REVIEW AND MANAGEMENT PROVISIONS OF THIS PROGRAM.

REFER TO THE "EXCLUSIONS" AND "SUMMARY OF COVERED SERVICES AND SUPPLIES" SECTIONS OF THIS BOOKLET TO SEE WHAT SERVICES AND SUPPLIES ARE NOT COVERED.

Horizon BCBSNJ will provide the coverage described in this Schedule of Covered Services and Supplies. That coverage is subject to the terms, conditions, limitations and exclusions stated in this Booklet.

Services and supplies provided by an In-Network Provider, are covered at the In-Network level.

Services and supplies provided by an Out-of-Network Provider, are covered at the Out-of-Network level. However, this does not apply to services and supplies provided by an Out-of-Network Provider in a case where: (a) the Covered Person is an Inpatient in a Hospital; (b) the admitting physician was a Network Practitioner; and (c) the Covered Person and/or the Covered Person's Practitioner complied with this Program's rules with respect to Prior Authorization or notification. In this case, the Covered Services and Supplies provided by Out-of-Network Providers during the Inpatient stay will be covered at the In-Network level.

Please note that you may be responsible for paying charges which exceed our Allowance, when services are rendered by an Out-of-Network Provider.

The laws of the State of New Jersey, at N.J.S.A. 45:9-22.4 et seq. mandate that a physician, chiropractor or podiatrist inform his/her patients of any significant financial interest he/she may have in a Provider when making a referral to that Provider. If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 or (800) 242-5846.

Different In-Network Providers have agreed to be paid in different ways. Your Provider may be paid: (a) each time he/she treats you (fee-for-service); or (b) a set fee each month for each Covered Person that the Provider treats, whether or not the Covered Person actually receives services (capitation). These payment methods may also include financial incentive agreements whereby some Providers are paid more (bonuses) or less (withholds), based on many factors.

Some of these factors are: member satisfaction; quality of care; control of costs; and use of services. If you want more information about how our Providers in our Network are paid, please call us at 1-800-355-2583 or write Horizon BCBSNJ, 3 Penn Plaza East, Newark, NJ 07105.

Coinsurance	**100%** of Covered Basic Charges.
In-Network	**100%** of Covered Supplemental Charges.
Coinsurance	**70%** of Covered Basic Charges.
Out-of-Network	**70%** of Covered Supplemental Charges.

Out-of-Pocket Maximum

In -Network	After **$5,000**/Covered Person, **$10,000**/family, We provide **100%** of Covered Allowance.
Out-of-Network	After **$10,000**/Covered Person, **$20,000**/family, We provide **100%** of Covered Allowance.

Note: The Out-of-Pocket Maximum cannot be met with:

- Non-Covered Charges

Deductible

In-Network & Out-of-Network Applies to Basic/Supplemental Services.	**$2,500**/Single **$5,000**/Family (**Note:** May be aggregately met by covered family members.)

Deductible does not apply to Preventive Care.

Common Accident Deductible - If two or more Covered Persons in the same family are injured in the same accident, only one Deductible will be applied in a Benefit Period to the Covered Services and Supplies due to the accident.

Prior Carrier Deductible Carry-Over - Charges for Covered Services and Supplies which met any portion of a Deductible required for the final Benefit Period under the Policyholder's prior group health benefits contract will be applied to meet all or any portion of the initial Deductible under this Program.

BENEFIT PERIOD MAXIMUM

In-Network and Out-of-Network	**Unlimited.** Applies to all Covered Services and Supplies.

PER LIFETIME MAXIMUM

In-Network and

EXCLUSIONS

The following are not Covered Services and Supplies under this Program. Horizon BCBSNJ will not pay for any charges Incurred for, or in connection with:

Acupuncture.

Administration of oxygen, except as otherwise stated in this Booklet.

Ambulance, in the case of a non-Medical Emergency.

Anesthesia and consultation services when they are given in connection with Non-Covered Charges.

Any part of a charge that exceeds the Allowance.

Any therapy not included in the definition of Therapy Services.

Bariatric Surgery.

Biofeedback services.

Blood or blood plasma or other blood derivatives or components that are replaced by a Covered Person.

Broken appointments.

Charges Incurred during a Covered Person's temporary absence from a Provider's grounds before discharge.

Completion of claim forms.

Conditions classified as V-codes in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. These include relational problems such as: parent-child conflicts; problems related to abuse or neglect when intervention is focused on the perpetrator; and situations not attributable to a diagnosable disorder, including bereavement, academic, occupational, religious and spiritual problems.

Conditions related to behavior problems or learning disabilities, except as may be required by law with respect to the treatment of Biologically-based mental Illness.

Conditions which Horizon BCBSNJ determines to be due to developmental disorders. These include, but are not limited to: mental retardation; academic skills disorders; or motor skills disorders. But, this does not apply: (a) to the treatment of Biologically-based Mental Illness; or disorders (b) to the extent needed to provide newly born dependents with coverage for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities.